| PROVIDENCE Health & Services Washington/Montana | **Original Effective Date:** 01/01/2000<br>**Last Revision Date:** 10/05/10<br>**Revision Effective Date:** 11/01/10 | **Page**<br><br>**1 of 6** | **Policy Number FIN-300** |
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| **Subject: Charity Care** | **Authorization: WA/MT Region CFO** | | |

**Purpose:**

"(Providence Health & Services – Washington/Montana hospitals)" are united in providing care based on the following principles:

- At Providence, we provide care to all those in need regardless of their ability to pay. This is an important part of our Mission.
- Each hospital will have financial assistance procedures that are consistent with the Mission and Values of Providence Health & Services. These procedures, which should be broadly communicated, should reflect a commitment to provide financial assistance to patients who cannot pay for part or all of the care they receive.
- Our Financial Assistance policies must maintain a careful balance between the need for fiscal stewardship and our bias toward the charitable Providence mission.
- All patients should be treated fairly, with dignity, compassion and respect.
- This policy will apply to Providence staff, providers and agents and require adherence to its standards and scope of practices.

**Policy:**

It is the policy of Providence to promote the health and well being of the people in the communities that we serve. Facilities within Providence Health & Services will provide medically necessary health care services to members of the community who are unable to pay for such services. A person will not be eligible for Financial Assistance under this Policy when the person enters the States of Washington or Montana strictly for non-emergent medical care. Financial Assistance will be considered if a person enters Washington or Montana from a bordering state, or outside of the community service area, seeking medically necessary treatment and one of the following applies:

- The PH&S facility is either closer in distance to their home address.
- The closest facility to their home address doesn't provide the medically necessary service.
- They are referred by a licensed provider to the PH&S Facility or its providers (Licensed Provider is referring patient to the PH&S facility because they do not provide the medically necessary service, and/or the PH&S facility is closer in distance to their home).

The community for each service area is defined as the geography that represents approximately 70-80% of its inpatient hospital admissions.

With the foundation and commitment of our Christian Heritage and values of our mission, we will provide a comprehensive continuum of services in collaboration with partners who share the same vision and ideals.

It is the responsibility of the Providence service facility to respond to all patient requests for charity eligibility during any one or more patient business interactions; namely pre-registration, registration, and discharge; or at any other time the Providence representative encounters information detailing the patient's financial need. Charity will be re-screened throughout the revenue cycle when account events trigger review.

It is the responsibility of the patient to actively participate in the financial assistance screening process and in providing requested information on a timely basis, including without limitations providing the hospital with information concerning actual or potentially available health benefits coverage (including available COBRA coverage), financial status (i.e. income, assets) and any other information that is necessary for the hospital to make a determination regarding the patient's financial and insured status. In addition, if the hospital reasonably determines that COBRA coverage is available to the patient, the patient shall provide the hospital with information necessary to determine the monthly premium due for said coverage and identify the patient's needed financial assistance from the hospital to make any such premium payments. The Revenue Cycle Director will be required to sign for all approved COBRA payment by Providence.

Charity approval will affect all accounts for which the approved guarantor is responsible for. The approved charity percentage will be applied to all existing accounts with debit balances. Any patient credit balance created by applying the charity percentage will be refunded to the guarantor within thirty (30) days of receiving the charity care designation. Accounts may also be returned from Bad Debt status if financial circumstances warrant and charity may be applied. Patients requesting charity may be required to apply for Medicaid benefits. If Medicaid eligibility was established for dates of service covered under charity, those charity adjustments will be reversed and the services will be billed to Medicaid for processing.

A set of Charity Care assessment guidelines, will be documented to supplement this policy. These guidelines will be consistent with all applicable state and federal laws as well as detail the following:

- Pre-Screen triggers for admitting and pre-registration staff.
- Non-Covered Services (Elective Cosmetic services, etc.).
- Procedures for Information Distribution (signage placement, pamphlet distribution, application distribution, etc.).
- Full Charity care sponsorship for those at or below 200% of the federal poverty standard.
- Other self-pay options for patients denied charity based on income. (Payment plan; Uninsured Discount, Prompt Payment Discount).

**Eligibility Requirements:**

- Eligibility shall be based on financial need at the time of application.
- Patients that are required to pay co-pays, co-insurance, deductibles, and fees based on entering a court deferred or other legal program, will not be eligible for Charity Care.

- All resources of the household, to include guarantor and spouse (when applicable) are considered together.
- All guarantors, with family income[1] equal to or below one hundred percent of the federal poverty standard, adjusted for family size, shall be determined to be indigent persons qualifying for charity sponsorship for the full amount of hospital charges related to appropriate hospital-based medical services that are not covered by private or public third-party sponsorship. Eligibility shall be based solely on the total gross family income adjusted for family size. Assets shall not be considered.
- All guarantors, with family income between one hundred one and four hundred percent of the federal poverty standard, adjusted for family size and assets, shall be determined to be indigent persons qualifying for discounts from charges related to appropriate hospital-based medical services in accordance with the sliding fee schedule in Attachment A and policies regarding individual financial circumstances based on the below criteria.
- For those with family income greater than 100% of the federal poverty level, exempt assets (based on minimum Medicaid exempted assets) listed below will not be added to family worth for charity consideration:

    - Family's principle residence.
    - Motor vehicle(s).
    - Personal effects and household goods.
    - Resources necessary for self-support: All resources of both spouses are considered together. Certain resources are excluded such as the home, household goods, personal effects, vehicles, and life insurance with a face value not more than $1,500. Most burial plots and prepaid, revocable burial plans not exceeding $1,500, or irrevocable burial plans are also excluded and not counted toward the resource limit.
    - Burial space and up to $1,500 for burial fund.
    - Life insurance policy up to $1,500.
    - Earned income tax credit (EITC) in the month received and the following month.
    - Income tax refunds in the month of receipt.
    - Basic State issued Food benefits.
    - Bona fide loans, including student loans.
    - Adoption support payments.
    - Foster care payments provided under Title IV-E and/or state foster care maintenance payments.
    - A Trust Fund when unavailable. A trust fund is considered unavailable when:
        - A household member cannot revoke the trust or change the beneficiary.
        - The trustee administering the funds is not under the direction of a household member or is appointed by the court with court-imposed limitations ion the use of the funds.
        - The funds are used solely to make investments on behalf of the trust or pay for medical or educational expenses for a specific household member; and
        - The investments made on behalf of the trust do not directly involve or assist any business or corporation under the control, direction, or influence of a household member; or

[1] As defined in WAC 246-453-010(17).

        - The patient must petition the court to release part or all of a resource, including funds in blocked accounts or trusts.

    - Specified employer sponsored retirement/pension plans e.g., 401(K), 403(b), IRA, ROTH IRA. (Monthly income drawn from investments will be added as family worth for charity consideration).

- Documentation will be requested and in most cases will be required to establish eligibility for charity care; however the absence of documentation in certain circumstances deemed reasonable and understandable by the provider's billing staff (e.g., homeless person) will not necessarily require a charity denial and may be considered for Charity Prima Facie Approval.
- Department management or senior management may approve charity care in extenuating circumstances.

**Evaluation Process:**

The process for determining which patients qualify for charity care will include:

- Exhausted or not eligible for any third-party payment sources.
- All possible insurance payors have been billed.
- Charity may supplement Medicare benefits.
- Patients requesting charity on accounts may be required to apply for Medicaid benefits. Charity may supplement Medicaid benefits, especially in the case of Family Planning Only benefits and non-covered services.
- Making an initial determination whether the patient is eligible for charity care, prior to initiating any collection efforts, assuming the patient cooperates with the organization's attempt to make the determination.
- Making the initial determination prior to service, at the time of service, or as soon as practical after service has been provided to the patient.
- Making reasonable attempts to determine if a third-party payor or sponsor may pay some or all of the charges.
- Providing all patients who have been initially determined to meet the criteria for charity care with at least fourteen (14) business days, or such time as may be reasonably necessary given the patient's medical condition, to provide any required documentation before the organization reaches a final decision whether the patient is eligible for charity care. The organization will notify the patient of its final determination within fourteen (14) business days of receiving the necessary documentation.
- Not imposing any unreasonable burden upon the patient to provide relevant information when considering the application for charity care. The organization may require the patient to validate the accuracy of any information provided. Any of the following documents shall be considered sufficient evidence upon which to base a determination of eligibility for charity care: proof of current income, current bank statements and/or income tax return from the previous year, W-2 statements from the previous year, verification of liquid/non-exempt funds (e.g. Money Market accounts, Certificate of Deposit, Pension benefits, savings and other non employer based retirement plans); unemployment compensation forms, forms approving or denying Medicaid or written statements from employers or welfare agencies: or federal or state award letters.

- If an application is completed but there is no documentation provided for proof of zero income, the application will be classified as Charity Care Undocumented. If patient does not complete an application, Charity Prima Facie Approval may be considered.
- Notifying the patient of the organization's decision, (approval or denial), the grounds for reaching the decision, and the process for appealing the decision if the organization deems the patient ineligible for charity care.
- If charity care is denied, providing the patient with thirty (30) calendar days within which to appeal the decision, correct any deficiencies in documentation, or request a review of the denial. Within the first thirty (30) days following a denial, the organization may not refer the patient's account to an external collection agency. If Providence upholds the denial, the patient, the service area CFO and the Washington State Department of Health will be notified in writing of the denied appeal. If no request for review is made during that thirty (30) day period, the organization may then initiate collection activities. If the organization has initiated collection activities and then discovers a request for review has been made, the organization will stop collection efforts until the review is completed.
- Allowing a patient to apply for charity care at any point from pre-admission to final payment of the bill, recognizing that a patient's ability to pay over an extended period may be substantially altered due to illness or financial hardship, resulting in a need for charity services. If the change in financial status is temporary, the organization can choose to suspend payments temporarily rather than initiate charity care.

**Billing and Collection Practices:**

- Hospitals will have written policies about when and under whose authority patient debt is advanced for collection, and should use their best efforts to ensure that patient accounts are processed fairly and consistently.
- Hospitals shall ensure that practices to be used by their outside (non-hospital) collection agencies will conform to the standards set forth in this policy, and shall obtain written commitments from such agencies that they will adhere to those standards. Hospitals should also conduct an assessment of each collection agency's adherence to the policy. Such assessment should be conducted at least annually.
- At time of billing, hospitals shall provide to all low-income uninsured patients the same information concerning services and charges provided to all other patients who receive care at the hospital.
- When sending a bill to a patient, hospitals shall include a) a statement that indicates that if the patient meets certain income requirements the patient may be eligible for a government-sponsored program or for financial assistance from the hospital; and b) a statement that provides the patient with the name and telephone number of a hospital employee or office from whom or which the patient may obtain information about the hospital's financial assistance policies for patients and how to apply for such assistance.
- Any patient seeking financial assistance from the hospital (or the patient's legal representative) shall provide the hospital with information concerning health benefits coverage, financial status (i.e. income, assets) and any other information that is necessary for the hospital to make a determination regarding the patient's status relative to the hospital's financial assistance policy, discounted payment policy, or eligibility for government-sponsored programs.

- For patients who have an application pending determination for either government-sponsored coverage or for the hospitals own financial assistance program, a hospital shall not knowingly send that patient's bill to a collection agency.
- Eligibility for financial assistance will be determined as closely as possible to the date of service.

**Communication to the Public:**

- Each hospital shall post notices regarding the availability of financial assistance to low-income uninsured patients. These notices shall be posted in visible locations throughout the hospital such as admitting/registration, billing office, emergency department and other outpatient settings.
- Every posted notice regarding financial assistance policies shall contain brief instructions on how to apply for financial assistance or a discounted payment. The notices also shall include a contact telephone number that a patient or family member can call to obtain more information.
- Hospitals shall ensure that appropriate staff members are knowledgeable about the existence of the hospital's financial assistance policies. Training shall be provided to staff members (i.e., billing office, financial department, etc.) who directly interact with patients regarding their hospital bills.
- When communicating to patients regarding their financial assistance policies, hospitals should attempt to do so in the primary language of the patient, or his/her family, if reasonably possible, and in a manner consistent with all applicable federal and state laws and regulations.
- Hospitals shall share their financial assistance policies with appropriate community health and human services agencies and other organizations that assist such patients.

**CONSEQUENCES:**

Violation of this policy may constitute grounds for immediate disciplinary action, up to and including termination of employment, service, or association with PH&S.

**AUTHORIZATION:**

Dan Harris, Chief Financial Officer
Washington/Montana Region

*Signature on file* Date: *10/29/2009*

**ATTACHMENT A**
**Charity Percentage Sliding Scale**

| % Federal Poverty Level | Adjustment |
|---|---|
| 200.00% | 100.00% |
| 222.00% | 90.00% |
| 244.00% | 80.00% |
| 267.00% | 70.00% |
| 289.00% | 60.00% |
| 311.00% | 50.00% |
| 333.00% | 40.00% |
| 356.00% | 30.00% |
| 378.00% | 20.00% |
| 400.00% | 10.00% |
| 401.00% | 0.00% |